



# State of Utah

Michael O. Leavitt  
Governor

Rod L. Betit  
Executive Director

Iona M. Thraen  
Division Director

Jan M. Buttrey  
Bureau Director

## BUREAU OF EMERGENCY MEDICAL SERVICES

288 North 1460 West

P.O. Box 142004

Salt Lake City, Utah 84114-2004

Telephone: (801) 538-6435

Fax: (801) 538-6808

### DIVISION OF HEALTH SYSTEMS IMPROVEMENT

**The Utah Department of Health, Bureau of Emergency Medical Services has been awarded a Rural Access to Emergency Devices federal grant for Automatic External Defibrillators.**

**Grants are available to rural counties in the state as defined by the federal program; this means 25 of 29 counties are eligible. Those counties not eligible are Weber, Davis, Salt Lake, and Utah Counties.**

**The Bureau of EMS has created an application process for this program. Applications and/or information are available from members of the coalition partnership formed for this program; i.e., the Utah Sheriffs Association members (local sheriffs), the Utah Fire Chiefs Association members (local fire chiefs), and the Bureau of Emergency Medical Services.**

**A priority system has been established to determine applicant eligibility. The priorities are in the following order:**

1. Licensed or Designated EMS first responders without AEDs;
2. Licensed or Designated EMS first responders with AEDs greater than five years old and little or no replacement support;
3. Public safety entities not designated as first responders;
4. Public or community buildings or gathering places (public access defib).

**A sustainability plan and a Memorandum of Agreement (MOA) between recipients and the Bureau of EMS are required for participation in this project. Questions can be directed to the Utah Department of Health, Bureau of Emergency Medical Services, P. O. Box 142004, Salt Lake City, Utah 84114-2004 or calling (801) 538-6295 or 1-800-284-1131. Applications must be received in the EMS Office before 5:00 p.m. on January 9, 2004. Applications received after this date will not be considered. Eligible applications will be reviewed, and award decisions will be based on the priority system, the justification narrative and the sustainability plan contained within the application.**

**The goals of the program are to place AEDs in the community and increase community awareness and knowledge. The project will place, ensure training, and track the use of these AEDs.**



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## DIVISION OF HEALTH SYSTEMS IMPROVEMENT

### RAED Application Details

#### 1. Name of Agency/Entity

- Provide the full and correct name of your agency/business
- If you are a pre-hospital agency, provide your agency number

#### 2. Phone

- Provide the current telephone number for your agency/business

#### 3. Name of Responsible Person

- This is the contact person who will be responsible for the oversight and monitoring of the AED, and training coordination.

#### 4. Phone

- Provide a telephone number to contact your Responsible Person.

#### 5. Mailing Address

- Provide the current mailing address of your agency/business. If your mailing address is different than the AED placement address, please indicate the placement address in section 10 of this application.

#### 6. Status of Recipient

- Indicate which category describes your agency/business. If your agency/business is not listed, check **other** and describe in the section provided.

#### 7. Current AED

- Is there currently an AED placed within your agency/business. Please indicate Y or N and describe the brand, model and age of the machine.

#### 8. Description of need **(THIS SECTION CARRIES SIGNIFICANT WEIGHT IN THE DETERMINATION OF AWARDS)**

- Please describe the need to place an AED at your agency/business. Be descriptive. Examples: high rate of cardiac emergencies, high senior population, large group gatherings etc.

#### 9. Sustainability Plan.

- On a separate piece of paper describe your agency/business' plan to sustain your AED placement beyond the expiration date of this program.

#### 10. Where will the AED be placed

- Describe where the AED will be placed. Describe the location within the building or vehicle, i.e. hallway, wall, drawer, cabinet, trunk etc. What is the physical address of the AED placement if different from your agency/business mailing address.

#### 11. CPR/AED Training

- Identify the number of employees you anticipate to provide CPR/AED training for. If your agency is able to provide this training, identify your Instructor.

#### 12. Memorandum of Agreement

- Read and sign the Memorandum of Agreement included in the application packet.

#### 13. Signature

- By signing this application agree that you are the Responsible Person and you have read and fully understand the terms of this program, including the expectations of AED placement, sustainability plan, training and reporting.

**KAED Application**  
Utah BEMS RAED Grant Program  
Bureau of Emergency Medical Services  
Utah Department of Health

**Completed applications must be received by January 9, 2004.**  
**Mail to: BEMS, attn: Don Wood, PO Box 142004, Salt Lake City, Utah 84114-2004**

|  |      |                     |
|--|------|---------------------|
| 1. Name of Agency/Entity:  |      | 2. Phone:           |
| 3. Name of Responsible Person:   |      | 4. Phone:           |
| 5. Mailing Address:  |      |                     |
| City:  | Zip: | County:             |
| 6. Status of Recipient:  |      |                     |
| ( ) Pre Hospital EMS Agency #  |      | ( ) Fire Agency     |
| ( ) Medical Provider (Hospital, Clinic, Nursing Home, etc ..)  |      | ( ) Dispatch Agency |
| ( ) Law Enforcement agency   |      | ( ) Business        |
|  |      | ( ) Other           |
| 7. Do you currently have an AED : Y    N    Make/Model   |      | Age:                |
| 8. Description of need:  |      |                     |
|  |      |                     |
| 9. Sustainability plan (please attach on a separate sheet of paper)  |      |                     |
| 10. Where will the AED be placed? (Be specific)  |      |                     |
|  |      |                     |
| 11. How many people will be CPR/AED trained?   |      |                     |
| Can you provide CPR/AED training?                    Y        N  |      |                     |
| If you answered yes, please identify your CPR/AED Instructor.  |      |                     |
| 12. Memorandum of Agreement (Read, sign and attach the Memorandum of Agreement accompanying this application)  |      |                     |
| 13. As a recipient of an AED provided by the Federal Access to Emergency Devices Grant Program through the Utah State Bureau of Emergency Medical Services, I agree to fulfill the requirements of the grant and to adhere to the laws and rules of the State of Utah. |      |                     |
| _____<br>Signature of Responsible Person   |      | _____<br>Date       |
| _____<br>Printed Name  |      |                     |



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## DIVISION OF HEALTH SYSTEMS IMPROVEMENT

### MEMORANDUM OF AGREEMENT

This agreement is made and entered into by and between the Department of Health, Division of Health Systems Improvement, Bureau of Emergency Medical Services hereinafter called the DEPARTMENT, and (name) \_\_\_\_\_ hereinafter called the PROVIDER.

#### AGREEMENT PERIOD

This agreement shall be in effect for a time period of five years or until either the DEPARTMENT or the PROVIDER agrees to terminate this relationship. This agreement may be terminated after a written notification is sent to either party at least 30 days in advance of the termination.

#### AGREEMENT

1) The PROVIDER agrees to:

- a) Develop a plan describing how the AED will be monitored to ensure that the battery is in good working condition, that the selfchecks show no faults, and that any periodic maintenance required by the manufacturer will be accomplished.
- b) Report any usage of the AED through a DEPARTMENT-approved reporting system, which includes required data elements.
- c) Install the AED in a location that is known by qualified providers and can be accessed by the providers without delay.
- d) Designate a person who is responsible to comply with all the provision of this agreement.
- e) Replace the AED if lost, stolen, or damaged beyond repair, for reasons of negligence on the part of the PROVIDER.
- f) Replace the battery and electrodes when either is used or they become expired.
- g) Hold the DEPARTMENT harmless from liability arising from any use or misuse of the AED. However, this does not constitute a waiver of immunity under the Utah Government Immunity Act, Title 63, Chapter 30, UT.CODE.
- h) Provide a sustainability plan for the provision of an AED after the five-year grant period.

2) The DEPARTMENT agrees to:

- a) Provide a set amount of funds to the PROVIDER for the purchase of each AED awarded to the PROVIDER.
- b) Coordinate and provide a one-time CPR/AED training as identified by priorities and funding availability.

## TERMINATION OF THE AGREEMENT

**IT IS AGREED THAT** any alteration, variations, modifications, or waivers of the provisions of this agreement will be valid only when reduced to writing and approved by the DEPARTMENT.

**THIS AGREEMENT** may be canceled, and all grant activities halted, by the DEPARTMENT, at any time, for unsatisfactory performance of the terms and conditions of this agreement.

Utah Department of Health  
Bureau of Emergency Medical Services

PROVIDER

\_\_\_\_\_  
Date \_\_\_\_\_

\_\_\_\_\_  
Date \_\_\_\_\_